SERVICE REDUCTION OPTIONS

Please Note
The sequence in which items are presented is not meant to imply a priority order.

For Review and Prioritization

by the

Joint Legislative and Executive Task Force On Mental Health Service Delivery and Financing

SERVICE REDUCTION OPTIONS

Option #1: ELIMINATE OUTPATIENT TREATMENT FOR "NON-PRIORITY" MEDICAID ADULTS

Description: Establish and enforce an "access to care" standard under which Medicaid adults would need to meet one of the state Priority Population definitions, or have a Global Assessment of Functioning score of 60 or lower at intake, in order to qualify for outpatient services.

See Appendix C for complete state "Priority Population" definitions, and Appendix E for global assessment indicators.

FY 03 Persons Served: 3,200 Medicaid Adults

Potential State Savings: ($1.0 Million)

Estimated Impact of Continued Funding

This “access to care” standard has been approved by CMS and is currently in effect and being implemented. Transitions have already begun in terms of determining (and limiting) admission to the public mental health system based on this standard. The level of funding identified above with the FY03 client group that did not meet these standards may in fact be needed to ensure consistent statewide access and comparable Medicaid penetration rates around the state in order to be in compliance with current CMS access standards.

Estimated Impact of Reduced or Eliminated Funding

“Front doors” to the system have already been tightened as the CMS Access to Care Standards and other regional admission criteria have been implemented since FY03, the time period represented in the service data and cost figures above. As a result, FY03 statistics may not reflect the current reality of Medicaid access to the public mental health system, which is likely to be closer to the proposed access standard than the 03 data would suggest. Therefore, part or all of these funds may be needed to ensure compliance with the CMS access standards for Medicaid eligible adults across the state.

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Option #2: ELIMINATE OUTPATIENT TREATMENT FOR "NON-PRIORITY" MEDICAID CHILDREN

Description: Establish and enforce an "access to care" standard under which Medicaid children would need to meet one of the state Priority Population definitions, or have a Children's Global Assessment Scale score of 60 or lower at intake, in order to qualify for outpatient services.

See Appendix C for complete state "Priority Population" definitions, and Appendix E for global assessment indicators.

FY 03 Persons Served: 8,000 Medicaid Children

Potential State Savings: ($3.8 Million)

Estimated Impact of Continued Funding

This “access to care” standard has been approved by CMS and is currently in effect and being implemented. Transitions have already begun in terms of determining (and limiting) admission to the public mental health system based on this standard. The level of funding identified above with the FY03 client group that did not meet these standards may in fact be needed to ensure consistent statewide access and comparable Medicaid penetration rates around the state in order to be in compliance with current CMS access standards.

Estimated Impact of Reduced or Eliminated Funding

“Front doors” to the system have already been tightened as the CMS Access to Care Standards and other regional admission criteria have been implemented since FY03, the time period represented in the service data and cost figures above. As a result, FY03 statistics may not reflect the current reality of Medicaid access to the public mental health system, which is likely to be closer to the proposed access standard than the 03 data would suggest. Therefore, part or all of these funds may be needed to ensure compliance with the CMS access standards for Medicaid eligible children and youth across the state.

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Option #3: ELIMINATE OUTPATIENT TREATMENT FOR "NON-PRIORITY" MEDICAID ADULTS WITH MODERATE IMPAIRMENTS

Description: Establish and enforce an "access to care" standard under which Medicaid adults would need to meet one of the state Priority Population definitions, or have a Global Assessment of Functioning score of 51 or lower at intake, in order to qualify for outpatient services.

See Appendix C for complete state "Priority Population" definitions, and Appendix E for global assessment indicators.

FY 03 Persons Served: 2,400 Medicaid Adults

Potential State Savings: ($1.0 Million)

Estimated Impact of Continued Funding

Adults who meet one of the state priority populations, and/or have an intake Global Assessment Functioning score between 51 and 60 represent a group of individuals with serious clinical needs, These adults are recognizable in the community as having noticeable and serious mental health related problems. They are best treated on an outpatient basis in terms of both cost to the system and positive outcomes. The earlier that treatment intervention occurs, the more likely the potential for long-term successful outcomes, improved functioning and increased self-sufficiency. The mental health related problems experienced by this clinical group will not go away without treatment. Untreated serous disorders can result in increased symptoms, decompensation and decline in functioning, involuntary detentions and hospitalizations. The average cost of outpatient care for this population is $417/adult/year.

Estimated Impact of Reduced or Eliminated Funding

In order to implement this funding reduction, the current Access to Care Standards would need to be re-negotiated with CMS. It may be difficult to make the clinical argument that Medicaid adults with a presenting GAF score above 50 have no “medical necessity” for mental health treatment, and CMS may not approve the change. If GAF access scores **are** lowered to 50 or below, with reduced or no access to outpatient treatment, this disabled population will become increasingly dependent on crisis services; clinical symptoms and problems will deteriorate in some cases to the level of ITA referral and/or need for inpatient hospitalization. Utilization statistics indicate that individuals who receive only crisis services are far more likely to have a CDMHP investigation (often leading to detention and/or longer-term hospitalization) than those receiving outpatient services are. Long-term positive treatment outcomes are jeopardized, and there is increased risk of suicide, as well as involvement in substance abuse and criminal activities. In addition, when mental health treatment is not provided, medical costs to Medicaid are likely to increase, and housing stability can be disrupted leading to increased numbers of homeless mentally ill adults in our communities.

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Option # 4: REDUCE ADMINISTRATIVE ACTIVITIES

Description: Eliminate specific administrative activities to achieve cost reductions. Examples of activities that should be considered for reduction include:

- Consolidate the number of Regional Support Networks (RSNs) from the current 14 to no more than 9. The savings estimate presented below assumes that state law would be changed to require that RSNs have a minimum population of 300,000, rather than the current standard of 40,000. This would require the Chelan-Douglas; Grays Harbor; North Central (Adams, Grant, and Omak counties); Northeast (Ferry, Lincoln, Pend Oreille, and Stevens); and Southwest (Cowlitz) RSNs to consolidate into larger RSNs.
- Reduce the frequency or duration of the certification reviews conducted by Mental Health Division staff. Instead, use the results of the new federally require "external quality review organization" (EQRO) to evaluate RSN performance.
- Eliminate the Quality Review Teams (QRTs), through which teams of consumers and other interested citizens conduct periodic monitoring of provider and RSN performance.
- Eliminate the longitudinal study mandated by RCW 71.24.840 under which the Washington State Institute for Public Policy is assessing changes in client status at two, five and ten years.
- Eliminate the TeleSage client outcome tool, and replace it with an outcome report card that uses data already collected from other sources.

FY 03 Persons Served: 127,000 Medicaid and non-Medicaid children and adults.

Potential State Savings (using FY 03 costs)

• **RSN Consolidation**	**($1.0 Million)**
• **EQRO/RSN Certification**	**($0.003 Million)**
• **Eliminate Quality Review Teams**	**($0.2 Million)**
• **Eliminate Longitudinal Study**	**($0.1 Million)**
• **Eliminate TeleSage Outcome Tool**	**($0.1 Million)**
Total	**($1.4 Million)**

Estimated Impact of Continued Funding

- Smaller RSN arrangements help assure that services are attuned to local needs, resources, and priorities in the many sparsely populated areas of the state. Additionally, such arrangements are not necessarily less efficient than their larger counterparts, since they can operate with less bureaucratic overhead, and share some functions with provider agencies. Because the number of provider agencies would likely stay the same, consolidation would not reduce most finance, contract monitoring, utilization management, and other administrative functions, without a commensurate reduction in accountability.
- MHD staff time that can be freed up from certification reviews as a result of the new external quality review organization function needs to be diverted to promoting compliance with new federal Medicaid requirements, and/or in providing technical assistance on implementation of evidence-based practices.

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Option # 4: REDUCE ADMINISTRATIVE ACTIVITIES (continued)

Estimated Impact of Continued Funding (continued)

- The Quality Review Teams provide an opportunity for consumer and advocate involvement in program monitoring that is important to some stakeholders.

- The TeleSage tool shows promise of being a state-of-the-art process for tracking outcomes at all levels of the community mental health system – individual, provider, RSN, and statewide. There has been a substantial investment in its development and initial implementation. The benefits of that investment are only now beginning to be known.

Estimated Impact of Reduced or Eliminated Funding

A reduction in duplicative or lower priority administrative activities reduces administrative burdens at the MHD, RSN, and provider levels and frees resources for direct consumer care.

- RSN consolidation should allow for a reduction in some duplicative functions – for example, the number of data systems to be supported, the number of offices, the number of staff needed to monitor service utilization and contract performance. Additionally, some of the current RSN structures may be too small to successfully meet the new, more challenging administrative requirements imposed by new federal Medicaid rules.

- By clearly defining the duties to be performed by the new external quality review organization (EQRO) vs. those performed by DSHS's RSN certification function, and eliminating any overlap, it should be possible to reduce administrative costs in the MHD central office, and administrative burden for RSNs and providers.

- Elimination of the Quality Review Team function should eliminate duplicative reviews of RSN, provider and allied system activities already accomplished by the MHD, and by others such as the local Ombuds, and the RSN complaint and grievance function.

- Elimination of the longitudinal study would lose an opportunity to track individual client outcomes and recovery over multiple years, rather than during a single year.

- A number of providers and RSNs do not find the TeleSage outcome tool to be useful in direct clinical services, system management, or in demonstrating system performance. Outcome data, meeting the statutorily defined outcome priorities of the legislature, could be provided using data already collected by the MHD through its data dictionary.

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Option #5: REVISE CRIMINALLY INSANE AND MENTAL ILLNESS COMMITMENT LAWS TO REDUCE COSTS ASSOCIATED WITH INCREASED USE OF JAILS AND PSYCHIATRIC HOSPITALIZATION

Description: Legislation passed in 1998 (2SSB 6214) extended the criminal competency restoration process to misdemeanant defendants who have a history or pending charge involving actual, threatened, or attempted physical harm to people or property. The legislation also mandated that such defendants be evaluated for a 90-day civil commitment if they are still not competent to stand trial after up to 29 days of treatment. This option would continue to allow for competency restoration for specified misdemeanants, at the discretion of the court, but would discontinue automatic civil commitment evaluations following failed competency restoration. Individuals could instead be referred to county-designated mental health professionals (CDMHP's) for investigation for civil commitment. This change is expected to reduce the number of persons civilly-committed to the state hospitals, and associated hospital operating costs.

Annual Persons Served: In 2003, there were over 120 civil commitments at the state hospitals of misdemeanant offenders with a history of violent acts for whom competency had not been restored. According to the 2004 evaluation of 2SSB 6214 by the Washington State Institute for Public Policy (WSIPP), the median length of stay for persons civilly committed after not being restored to competency was 87 days. Assuming a mean length of stay of 90 days, the particular provision that would be repealed was associated with over 10,800 days of state hospital treatment in 2003

The WSIPP evaluation reported that the average misdemeanant defendant served under the provisions of 2SSB 6214 was a 40 year-old male. Over 90% were diagnosed as having schizophrenia, bipolar disorder, or another major psychotic disorder, and 44% had a substance abuse disorder. 36% had a previous felony conviction, and 57% a previous misdemeanor conviction.

Potential State Savings (using FY 03 state costs): ($0.4 Million)

This assumes a 60% reduction in the number of misdemeanant defendants who are civilly committed to the state hospital after a competency evaluation. Such a reduction is consistent with analysis reported in the WSIPP evaluation. (The savings figure presented here reflects the amount of "liquidated damages" RSNs were charged for over-utilizing their state hospital bed allocation in FY 03. Such charges, and consequently the potential savings to the RSNs from reduced hospital utilization, are several times larger than this in FY 04, but the FY 03 amount is presented because that is the base year against which costs and savings are being measured.)

Estimated Impact of Continued Funding

An evaluation of the changes in forensic laws due to 2SSB 6214 was published by the Washington State Institute for Public Policy (WSIPP) in 2004. The evaluation found that the legislation was working as intended, in that misdemeanant defendants evaluated as incompetent to stand trial and determined to be a threat to public safety received competency restoration treatment and, if not restored to competency, were more likely to be civilly committed under the new provisions of the law. The evaluation also found that defendants who were adjudicated and treated under the new law

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Option # 5: REVISE COMMITMENT LAWS (continued)

Estimated Impact of Continued Funding (continued)

were less likely to re-offend than were comparable defendants adjudicated under the previous law. Specifically, 9% of the post-6214 group were subsequently convicted of a felony, compared to 17% of the pre-6214 group; 26% were convicted of a misdemeanor, compared to 42% of the pre-6214 group

Estimated Impact of Savings Option

This change would reduce use of civil commitment beds at the state hospitals, and the extent to which RSNs are being charged “liquidated damages” due to exceeding their hospital bed allocation. Liquidated damages must be paid with state-only funds, which exacerbates the non-Medicaid funding crisis.

Recidivism would not necessarily increase as a result of this change, because providing outpatient treatment only, rather than in combination with a state hospital stay, may be as effective an intervention. This question was not explored by the WSIPP evaluation.

Some knowledgeable observers also believe that a change such as this could mitigate a potential unintended consequence of 2SSB 6214. It may be that, because the new law mandates treatment for the identified population, police are now more likely to arrest individuals and take them to jail, rather than call mental health professionals for crisis intervention or investigation for civil commitment. The unintended consequence, then, may be that more mentally ill individuals are being placed in jail instead of being referred to treatment alternatives.